



Spring 3-1-1993

Insurance Tax Policy And Health Care Reform: Back To The Future

Curt W. Fochtman

Frank E. Plan

Thomas J. Minor

Follow this and additional works at: <https://scholarlycommons.law.wlu.edu/wlulr>



Part of the [Insurance Law Commons](#), and the [Tax Law Commons](#)

Recommended Citation

Curt W. Fochtman, Frank E. Plan, and Thomas J. Minor, *Insurance Tax Policy And Health Care Reform: Back To The Future*, 50 Wash. & Lee L. Rev. 565 (1993).

Available at: <https://scholarlycommons.law.wlu.edu/wlulr/vol50/iss2/9>

This Article is brought to you for free and open access by the Washington and Lee Law Review at Washington and Lee University School of Law Scholarly Commons. It has been accepted for inclusion in Washington and Lee Law Review by an authorized editor of Washington and Lee University School of Law Scholarly Commons. For more information, please contact christensena@wlu.edu.

INSURANCE TAX POLICY AND HEALTH CARE REFORM: BACK TO THE FUTURE

CURT W. FOCHTMANN
FRANK E. PLAN
THOMAS J. MINOR*

I. INTRODUCTION

Congress' piecemeal approach to federal taxation of property-casualty insurance companies has created a system of taxation that detracts from health care reform. A system that starts with a goal of raising revenue and is rationalized in terms of "better matching of income and expense,"¹ "the time value of money,"² and "unfair competitive advantage"³ is unlikely to support necessary and meaningful health care legislation. Meaningful health care reform means making quality health care available at a reasonable price to individuals and small business employees. The authors submit that this goal is at odds with increasing taxes on the property and casualty insurance industry members that participate in providing health care. In order to align these goals, Congress should seriously consider providing tax incentives to insurance companies involved in the delivery of health care.

This essay explores the existing and historical schemes of federal taxation on property-casualty insurance companies involved in health care delivery and challenges Congress to recognize the integral relationship between insurance tax policy and health care reform. In particular, Congress should, at a minimum, (1) maintain the existing tax favored status of Blue Cross-Blue Shield organizations or other organizations that meet certain health care reform standards, (2) clarify the tax status of health maintenance organizations and (3) modify the tax rules that apply to medical malpractice insurance companies. These organizations play a significant role, directly or indirectly, in health care delivery in the United States and should be included in reforming its health care system.

Historically, Blue Cross-Blue Shield organizations and health maintenance organizations were exempt from federal taxation as charitable or

* Members of Ernst & Young's Southeast Region Insurance Tax Services Group. Curt W. Fochtmann, B.S. 1982, M.T.A. 1983, University of Alabama; Certified Public Accountant. Frank E. Plan, B.S. 1987, University of Alabama-Birmingham; Certified Public Accountant. Thomas J. Minor, B.S. 1989, Auburn University; Certified Public Accountant. The authors gratefully acknowledge the assistance and comments of Douglas H. Beverly of Eastern Health System, Inc. in compiling the research for this essay.

1. STAFF OF THE JOINT COMM. ON TAXATION, GENERAL EXPLANATION OF THE TAX REFORM ACT OF 1986 595 (1986) [hereinafter '86 ACT BLUE BOOK] (justifying imposition of 20% "haircut" on unearned premiums).

2. *Id.* at 601 (justifying discounting of loss reserves).

3. *Id.* at 584 (justifying repeal of Blue Cross-Blue Shield organizations' tax-exempt status).

social welfare organizations.⁴ More recently, however, Congress has chosen to impose an income tax on these organizations due to a perceived competitive advantage over commercial insurers which do not have tax-exempt status.⁵ The purpose of this essay is not to challenge whether this competitive advantage exists, but instead to ask whether all health insurance organizations that survive in the reformed health care environment should receive a favored tax status in the name of charity or social welfare.

Hospital and medical malpractice insurance companies provide professional liability insurance coverage to health care providers. Unfortunately, one of the costs incurred in providing health care in the United States is litigation expenses—including damage awards and legal fees—paid by malpractice insurance companies in medical and hospital malpractice law suits. The insurance companies that are willing to provide insurance coverage against health care service malpractice risks must also face an ever-increasing taxpaying and compliance burden. As a part of health care reform, Congress should consider revising the federal taxation of hospital and medical malpractice insurance companies with a view toward reducing the tax they pay and the costs they incur in complying with existing tax laws. The Tax Reform Act of 1986 (the 1986 Act)⁶ was a major setback in this regard. If Congress is serious about health care reform, it will recognize the critical role these companies play in health care delivery and provide them with incentives and means to reduce costs rather than increase them.

If Congress is successful in addressing the issues raised by this essay, federal tax revenues will decrease. In what has become traditional thinking, this decrease should be offset to maintain revenue neutrality. In the authors' view, this decrease should come in the form of reduced federal expenditures for health care rather than directly increased tax revenues from other taxpayers. In other words, one of the costs of providing health care is the tax health care entities pay. A reduction in taxes of these organizations should, therefore, provide a reduction in actual health care costs.⁷

II. BLUE CROSS-BLUE SHIELD ORGANIZATIONS

A. Background

Blue Cross-Blue Shield organizations found their beginnings in the late 1800s when Americans began to streamline some aspects of health care in

4. *Id.* (recognizing pre-1986 tax exemption of Blue Cross-Blue Shield organizations under I.R.C. § 501(c)(3) or § 501(c)(4)).

5. *Id.*

6. Pub. L. No. 49-514, 100 Stat. 2085 (codified as amended in scattered sections of 26 U.S.C.).

7. While a statistical analysis of the incidence of a marginal reduction in the income tax liabilities of property-casualty insurance companies is beyond the scope of this essay, the authors believe that increased incentives to private insurance companies may prove more efficient than public redistribution of such funds.

the United States.⁸ Early versions of what later became the Blue Shield concept began to appear in remote areas of Washington and Oregon. In these states commercial enterprises contracted directly with physicians to provide medical care for employees and their families.

At about the same time in Germany, employers provided employees with a health insurance plan under which the company paid all or part of each employee's doctor bills. In 1883, the German government adopted this idea as national law, making that country the first in the world with a national health insurance program.⁹

Other countries began to adopt the German model or similar forms of socialized medicine. In fact, in 1913, when Theodore Roosevelt ran for President on the Progressive Party Ticket, he suggested national health insurance as part of his platform.¹⁰ While he did not necessarily lose the election because of this idea, the concept of national health insurance faded away when Woodrow Wilson was elected President.

County medical societies soon began to form which offered contracting employers freedom to choose among any of their participating physicians. During the late 1920s, medical cooperatives began to form which allowed people who lived in rural areas to prepay a small monthly fee and then to come to the hospital without additional charge whenever they needed medical care.¹¹ Across much of the nation, most laborers had health care protection through their employers. Company owners, for example, paid local physicians, who many times owned their own hospital, a fee for coverage of each of his employees, and perhaps their families. For example, in Birmingham, Alabama, coal mining companies paid fifty cents a month so that a miner and his family could be insured for whatever care their physician network found necessary.¹²

There was still a gap that needed filling. Some laborers had protection through their large company employers. However, farmers, small business owners and wage earners like department store sales people, office clerks, teachers, and plant managers had no such health plan. The Great Depression of the late 1920s and early 1930s increased these problems as more and more responsible American workers fell behind in medical payments. These problems gave rise to the first Blue Cross-type plan in the United States which came about as a way to help school teachers in Dallas, Texas keep up with their medical bills at Baylor University Hospital.¹³ The plan was designed so that each teacher paid a small monthly fee and was entitled to twenty-one days of hospital care at no additional cost. Before 1930, a thousand Dallas area teachers had enrolled in the program. This plan was limited in usefulness, however, because teachers could only be treated at Baylor University Hospital.

8. RUTH BEAUMONT REUSE, *EVOLUTION OF THE CARING COMPANY* 13 (1991).

9. *Id.* at 14-15.

10. *Id.* at 15.

11. *Id.* at 15-16.

12. *Id.* at 16.

13. *Id.* at 17.

The prepayment idea extended beyond Baylor's single hospital-single group¹⁴ status in 1932 when hospitals in California organized a community wide prepayment plan.¹⁵ At about the same time, the Hospital Council of Essex County in Newark, New Jersey began a community wide prepayment program supported by all eighteen hospitals in the county.¹⁶ Within two years similar plans had been organized in Minnesota, North Carolina, New York, Louisiana and other states.

By 1930, thirty-nine Blue Cross plans were operating in the United States.¹⁷ When confusion began to arise about the legality of plans that allowed subscribers to choose which hospital would treat them, the American Hospital Association and local hospital groups decided to seek state legislation to create special nonprofit status for this type of hospital insurance.

As this approach was pursued, seven basic standards for nonprofit, group hospitalization plans were set:

1. Emphasis on public welfare,
2. Limitation to hospital services,
3. Freedom of choice of hospital and physician by subscriber,
4. Nonprofit sponsorship,
5. Compliance with legal requirements,
6. Economic soundness, and
7. Dignified and ethical administration.¹⁸

These standards were later expanded to include a fourteen-standard code for nonprofit hospital plans that is still the basis for Blue Cross plans today.¹⁹

B. Tax Reform Act of 1986

Because Congress viewed Blue Cross-Blue Shield organizations, or plans, as filling a critical gap in the health care system, the plans were exempt from federal income taxation under Internal Revenue Code (Code) sections 501(c)(3) or (4) until Congress's passage of the 1986 Act.²⁰ The 1986 Act's repeal of the plans' tax-exempt status resulted largely from Congress' perception that changes in the plans' operations brought the plans into competition with commercial insurers, and that the plans were no longer operating exclusively for the promotion of social welfare.²¹

The changes leading to repeal of the plans' tax-exempt status were gradual. Attracted by the success of the plans, commercial insurers steadily expanded their efforts in the health insurance industry, competing directly with the

14. A "group" is a number of persons considered as a collective unit by a health care provider, for example, employer groups, labor union groups, association groups.

15. REUSE, *supra* note 8, at 18.

16. *Id.*

17. *Id.*

18. *Id.* at 18-19.

19. *Id.* at 14-19.

20. I.R.C. § 501(c)(4) (Supp. 1993).

21. '86 ACT BLUE BOOK, *supra* note 1, at 584.

plans for the more profitable segments of the health insurance market. These taxable insurance companies soon assailed the plans' tax-exempt status as an unfair competitive advantage. During the same period, increased competition pressured many plans to review their internal operations, including the desirability of underwriting small groups and high risk groups. Faced with this situation, Congress recognized that while the availability of health insurance was generally assured by the participation of commercial insurers in the market, competition would result in coverage becoming too expensive, or simply unavailable, to small and high risk groups. The 1986 Act, which alters the plans' tax-exempt status to a tax-favored status by enacting Code section 833, reflects Congress' perception that the plans continue to play a valuable role in the nation's health care system, but a role less vital than that played at the time the plans were formed. While the plans have been incidentally affected by post-1986 tax acts, the general scheme of taxation established by the 1986 Act remains virtually intact.

Code section 833 applies to existing Blue Cross-Blue Shield organizations and other organizations that meet strict requirements. Code section 833(c) provides that the term "existing Blue Cross-Blue Shield organization" means any Blue Cross-Blue Shield organization if:

1. Such organization was in existence on August 16, 1986,
2. Such organization is determined to be exempt from tax for the last taxable year beginning before January 1, 1987, and
3. No material changes occur in the operation of such organization or in its structure after August 16, 1986, and before the close of this taxable year.²²

Code section 833(a) provides that a qualifying Blue Cross-Blue Shield organization will be treated for tax purposes as a stock property-casualty insurance company. However, Blue Cross-Blue Shield plans are exempt from the twenty percent reduction in unearned premium reserves the 1986 Act imposed on other property-casualty insurers because the plans generally do not incur and deduct up-front commissions like commercial insurers. Accordingly, the plans take into account one-hundred percent of the change in unearned premiums in determining taxable income.

Recognizing that the plans were still the primary, and in some instances only source of health insurance coverage for small and high risk groups, Congress created an inducement for the plans to continue serving small, high risk groups. Code section 833(b) permits Blue Cross-Blue Shield plans to take a special deduction equal to the excess, if any, of twenty-five percent of the sum of claims incurred during the taxable year, and expenses incurred during the taxable year in connection with the administration, adjustment, or settlement of claims, over adjusted surplus as of the beginning of the year.²³ The deduction is limited to the plan's regular health-related taxable income,

22. I.R.C. § 833(c) (1988).

23. I.R.C. § 833(b).

determined without regard to this special deduction and cannot increase or generate a net operating loss. The Code section 833(b) deduction enables some Blue Cross-Blue Shield organizations to avoid paying regular tax, but generally results in them being subject to the alternative minimum tax.²⁴

To insure that the plans continue to underwrite small and high risk groups after repeal of the tax-exempt status, Code section 833(c)(2)(C) conditions application of Code section 833 on there being no "material change," subsequent to August 16, 1986, in a plan's operation or structure. The General Explanation to the 1986 Act provides examples of material changes.²⁵ The merger or split up of plans, or the conversion to mutual company status, will not constitute a material change. If a plan acquires a new line of business or is acquired by another business, the acquisition will not be a material change if the assets of the other business are de minimis, or if the plan can demonstrate to the Internal Revenue Service (IRS) that the acquisition is not a material change. A material change does not occur if a plan increases its premium rates to reflect normal increases in health care costs or makes normal changes in products and services to respond to general changes in developments in the health care environment.

The plans were provided several transitional rules to facilitate the change from tax-exempt to taxable status. The initial hurdle was adoption of permissible tax accounting methods. Effective January 1, 1987, section 1012 of the 1986 Act granted the plans a "fresh start" in accounting methods.²⁶ As a result, no cumulative effect adjustments under Code section 481 were required. This "fresh-start" assured that income and deductions attributable to pre-1987 accounting periods—when Blue Cross-Blue Shield organizations were tax-exempt—would not effect the computation of post-1986 taxable income.

Section 1012 of the 1986 Act also granted the plans an adjustment in the basis of their assets to fair market value as of January 1, 1987, for purposes of determining gains or losses on dispositions.²⁷ This adjustment in basis does not apply for purposes of determining depreciation deductions. Furthermore, it appears appropriate that the basis determined as of January 1, 1987, for gain or loss purposes should be adjusted for post-1986 tax depreciation and amortization.

Also in the transition to taxable status, Congress required the plans to restate their January 1, 1987 claim reserves using actual paid claims data.²⁸ The plans were required to track the payments of their pre-1987 reserves in determining their January 1, 1987, opening reserve balances. Because of the rapid payout of accident and health reserves, the plans' pre-1987 claim reserves were generally paid out by December 31, 1987. However, where pre-1987

24. See I.R.C. § 56(c)(3) (Supp. 1993) (increasing corporate alternative minimum taxable income by amount of special deduction).

25. '86 ACT BLUE BOOK, *supra* note 1, at 587-88.

26. Tax Reform Act of 1986, Pub. L. No. 99-514, § 1012, 100 Stat. 2085, 2394 (1986).

27. *Id.*

28. *Id.*

claims remained outstanding as of December 31, 1987, the opening reserve balance was restated using actual paid claims data through December 31, 1987, plus the most accurate estimate available for future payments against pre-1987 reserves. The redetermined January 1, 1987 claim reserves were then discounted using the six month payout assumption under Code section 846(f)(6).

To eliminate the possibility a plan might artificially reduce, or weaken, its December 31, 1986 reserves (outside of the procedures described above), with the intent of increasing its 1987 losses incurred deduction, Act section 1012(c)(3)(C)²⁹ requires that any reserve weakening after August 16, 1986 be treated as occurring in the plan's first taxable year beginning after December 31, 1986.

C. Tax Policy Decisions for Blue Cross-Blue Shield Organizations

It is interesting to note that almost a century later America finds itself in a similar circumstance today with respect to health care as existed in the early 1900s when it was difficult if not impossible for farmers, small business owners and wage earners like department store sales people, office clerks, teachers, and plant managers to purchase adequate health care insurance. The problems at the beginning of this century gave rise to the first Blue Cross-type plans in the United States, and as we approach the end of the century, we believe that Congress should analyze the importance of Blue Cross-Blue Shield plans in today's health care system.

Blue Cross-Blue Shield organizations are major participants in the provision of health care in the United States. As of 1986, seventy-seven plans insured approximately 79,000,000 persons, or approximately one-third of the U.S. population at that time. In comparison, by 1986, approximately 111,000,000 persons were covered by more than 800 commercial health insurance companies.³⁰

This significant participation by Blue Cross-Blue Shield organizations requires Congress to recognize the major role they play in financing health care in the United States and to support them by at least maintaining their current tax-favored status. Other prepaid health coverage organizations which provide similar social welfare benefits should be provided similar tax-favored status. In fact, if organizations of this nature are to continue to play a major part in health care reform, additional incentives may be necessary.

As stated earlier, meaningful health care reform means making quality health care available at a reasonable price to individuals and small business employees. In order to reach this goal, Congress must first analyze the assets that currently exist in the health care industry and determine how best to utilize them in efficiently delivering quality health care to the American public. Congress's plan must not include a concept in which additional taxes

29. *Id.* at § 1012(c)(3)(C), at 2394.

30. General Accounting Office, Comparison of Blue Cross and Blue Shield Plans with Commercial Insurers, GAO/HRD-86-110 (1986).

are levied on the existing health care providers in order for the government to heavily regulate the industry. Instead, Congress should provide incentives for those involved in the health care process to function as efficiently and effectively as possible while providing quality, affordable health care to everyone.

Congress should enact legislation which insures that Blue Cross-Blue Shield and similar entities that provide coverage to the small and high-risk groups are taxed fairly and consistently. This may mean that tax-favored provisions such as those afforded to Blue Cross-Blue Shield entities in the 1986 Act are made available to other entities that are willing and able to provide services to the small and high-risk groups at affordable rates. Also, it may mean that additional tax incentives are necessary in order for these entities to operate under the pressures of health care reform.

Congress should consider providing a tax credit to these entities for the losses incurred with respect to the small and high-risk groups. This type of credit would insure quality, affordable coverage for these groups and would eliminate the need for the government actually to collect new taxes in order to provide this type coverage. Congress must realize that more benefits will be gained by leaving a dollar in the competitive private sector than by the government managing the dollar. If the reformed health care system requires all, or a large number of health care insurance companies, to cover small and high risk groups, the tax credit should be extended to all of these companies. Further, if small and high risk groups are combined into large community rated groups, a credit equivalent to the risk differential between average commercial groups and these new "manufactured" groups should be granted to the companies that provide the insurance. Other ideas for additional incentives for prepaid health coverage organizations involved in health care reform include: (1) tax credits for investment in electronic processing, digital storage and "smart card" technology to streamline health care billing systems, (2) tax credits for hiring specialized employees to help insure the quality of health care provided, (3) exemption from a new federal premiums tax, if any, and (4) tax credits for meeting specified health care cost reduction targets.

III. HEALTH MAINTENANCE ORGANIZATIONS

A. Background

Another segment of the health insurance industry that will be affected by health care reform is health maintenance organizations (HMO). HMOs represent one of the most rapidly growing components of today's health care industry. According to a recent analysis, HMOs will enroll nearly forty percent of privately insured individuals by the year 2000, up from twenty-three percent in 1992.³¹ HMOs provide managed health care benefits to their

31. *HMOs Projected to Enroll 40 Percent of Privately Insured Persons by 2000*, 20 Pens. Rep. (BNA) 914 (Apr. 26, 1993).

members in exchange for predetermined payments from each member. Managed health care benefits provided by HMOs primarily include physician care, specialist care, medical emergencies and hospital care. HMOs provide health care through a network of physicians and hospitals that deliver the necessary services to the HMO's members. Typical HMO models include staff model, group model, individual practice association (IPA) model, network model, and a mixture of models. HMO models are generally distinguished by the relationship between the HMO and its health care providers.

Staff model HMOs generally employ their own primary care physicians. Specialty medical and hospital care are generally provided under contract with third-party doctors and hospitals.

Group model HMOs contract with one group of private practice physicians. The HMO generally pays the group of physicians on a fixed monthly basis for each subscriber member of the HMO, that is, capitation payment. As with the staff model HMO, if the physician group cannot provide for a subscriber, the HMO will contract with outside specialists. A network model HMO is similar to a group model HMO except that under a network model, the HMO may contract with two or more physician groups.

IPA model HMOs contract with various physicians practicing independently. IPA model HMOs generally pay physicians on a capitation basis or on a fee for service basis. Additionally, an IPA model HMO may contract with a group of independent physicians. If contracting with an IPA, the HMO will generally pay the IPA on a capitation basis and the IPA, in turn, will reimburse its physicians on a fee for service basis. If the IPA cannot provide all the services required by the subscriber member, an outside specialist must be used. An outside specialist is generally compensated on a fee-for-service basis separate from the primary care physician or IPA capitation payments.

Many HMOs are structured as a mixture or combination of the types discussed above. As a result, the tax status of HMOs has become complex. The following is a discussion of the various tax considerations which all types of HMOs are faced with, including both tax-exempt and taxable HMOs.

B. Tax-Exempt HMOs

1. Prior to the 1986 Act

Before the 1986 Act, an HMO generally looked to the Tax Court's decision in *Sound Health Ass'n v. Commissioner*³² to determine whether it could qualify for exemption from federal taxation under Code section 501(c)(3). In *Sound Health*, the Tax Court ruled that for an HMO to be tax-exempt it must meet the criteria imposed on hospitals under Revenue Ruling 69-545,³³ which generally provides that a nonprofit hospital be organized and operated

32. 71 T.C. 158 (1978), *acq.*, 1981-2 C.B. 2.

33. 1969-2 C.B. 117.

exclusively for the furtherance of some charitable purpose. However, IPA model HMOs were not able to obtain exempt status in light of General Counsel Memorandum (GCM) 39057³⁴ which provided that an IPA is organized and operated primarily for the benefit of the IPA member physicians, not for a charitable purpose. HMOs, exclusive of IPA models, not meeting the criteria of *Sound Health* could qualify for exemption under Code section 501(c)(4) as social welfare organizations.

2. Subsequent to the 1986 Act

After the 1986 Act, Code section 501(m) provides that an organization may qualify for exempt status if no substantial part of its activities relates to providing commercial-type insurance.³⁵ The conference committee report to the 1986 Act and the Technical and Miscellaneous Revenue Act of 1988 (TAMRA) states that Code section 501(m) is not intended to affect the exemption of any HMOs.³⁶ However, the IRS believes that the exempt status of HMOs is at best unclear. In GCMs 39828 and 39859, the IRS stated that it does not read the legislative history to Code section 501(m) as indicating that HMOs should be recognized as not providing commercial-type insurance.³⁷ The IRS continues to believe that the commercial-type insurance provisions of Code section 501(m) should be based on the facts and circumstances of the particular case, not solely on whether the HMO operates as a staff, group, or IPA model. Code section 501(m) should not affect the tax-exempt status of the "common, existing" HMOs that compensate primary care physicians exclusively on a salary, capitation, or other fixed fee-for-service basis even though the HMO may pay other outside providers on a fee-for-service basis.³⁸

The IRS believes that the new mixed HMO organizations, such as point of service plans or open-ended HMOs, may be indemnity insurers. If a substantial part of "mixed" HMO activities consists of fee-for-service payments, they may not receive tax-exempt status.³⁹

An HMO must also qualify for tax-exempt status based on other factors. In GCM 39828, the IRS listed several factors that must be considered in determining whether an HMO can qualify as a tax-exempt charitable organization under Code section 501(c)(3). These considerations include:

34. Gen. Couns. Mem. 39057 (Sept. 19, 1982).

35. The General Explanation to the Tax Reform Act of 1986 refers to *Haswell v. United States*, 500 F.2d 1133 (Ct. Cl. 1974), *Seasongood v. Commissioner*, 1227 F.2d 907 (6th Cir. 1955), and Code section 501(h) for a definition of "substantial." '86 ACT BLUE BOOK, *supra* note 1, at 585.

36. H.R. CONF. REP. No. 841, 99th Cong., 2d Sess. II-345-46 (1986), *reprinted in* 1986 U.S.C.C.A.N. 4433, 4434; H.R. REP. No. 426, 99th Cong., 1st Sess. 665 (1985); S. REP. No. 445, 100th Cong., 2d Sess. 120-21 (1988), *reprinted in* 1488 U.S.C.A.N. 4637-4638.

37. Gen. Couns. Mem. 39828 (Sept. 30, 1990), 39,829 (Aug. 24, 1990).

38. Gen. Couns. Mem. 39829.

39. *Id.*

1. Actually providing health care services and maintaining facilities and staff,
2. Offering services to nonmembers on a fee-for-service basis,
3. Providing care and extending reduced rates to indigent persons,
4. Caring for persons covered by Medicare, Medicaid, and similar programs,
5. Making emergency room facilities available to the community regardless of an ability to pay, including informing the community about such services,
6. Operating a meaningful subsidized membership program,
7. Forming a board of directors broadly representative of the community,
8. Offering health education programs open to the community,
9. Conducting health research programs,
10. Having health care providers who are paid on a fixed fee basis, and
11. Using surplus funds to improve facilities, equipment, patient care or any of the programs described in the list.⁴⁰

Additionally, GCM 39828 lists other factors to determine whether an HMO meets the requirements of Code section 501(c)(3). These factors require that no meaningful restrictions be placed on the membership that would preclude the HMO from serving the community as a whole. These factors are:

1. Individuals compose a substantial portion of membership,
2. An active program exists to attract individual members,
3. Uniform rates for prepaid care are provided by a community rating system,
4. Individual and group members have similar rates, and
5. No substantive age or health barriers exist for determining eligibility for individuals or groups.⁴¹

In determining whether commercial-type insurance exists under Code section 501(m), GCM 39829 lists the following factors that must be carefully analyzed:

1. Whether an insurance risk is being transferred and distributed,
2. Whether, and to what extent, the entity is operated in a manner similar to for-profit insurers or Blue Cross and Blue Shield organizations,
3. Whether, and to what extent, the entity is marketing a product similar to for-profit insurers or Blue Cross and Blue Shield organizations,

40. Gen. Couns. Mem. 37828.

41. *Id.*

4. Whether, and to what extent, the entity provides health care services directly, and
5. Whether, and to what extent, the entity has shifted any risk of loss to the service providers through salary or fixed fee compensation arrangements.⁴²

In GCM 39829, the IRS listed exemption standards for Code section 501(c)(4) status similar to those for Code section 501(c)(3) status, only less restrictive. Thus, most HMOs will find it very difficult to satisfy the requirements for Code section 501(c)(3) or (4) exemption status under the 1986 Act.

In *Geisinger Health Plan v. Commissioner*, the Third Circuit Court of Appeals recently reversed a Tax Court decision holding that an HMO that intended to subsidize needy subscribers but only served paying subscribers did not qualify for exempt status.⁴³ In contrast to *Sound Health*,⁴⁴ the Court found that despite Geisinger's stated purpose of promoting health, the organization failed to confer sufficient benefit to the community.⁴⁵ On remand, the Tax Court held that Geisinger also failed to meet the exemption requirements as an integral part of a larger health care network.⁴⁶

C. Taxable HMOs

The operation and accounting practices of HMOs give rise to special tax issues for taxable HMOs. The taxation of an HMO that fails to qualify for exempt status depends primarily upon whether the HMO retains enough insurance risk to be taxed under Subchapter L of the Code as an insurance company or whether it shifts enough risk to the provider to be considered taxed as a regular corporation under Subchapter C of the Code.

An insurance company is generally defined as a company whose primary and predominant activity is the business of issuing insurance contracts. This is a subjective test, which can generally be achieved if the company can demonstrate that more than fifty percent of its business relates to the issuance of insurance-type contracts.⁴⁷ An insurance contract exists if the provisions of such contract shift or distribute risk. Risk shifting and risk distribution concepts were first defined by the Supreme Court in *Helvering v. LeGierse*⁴⁸ and have been further developed over the years. Most recently the Courts have explored the concept of risk shifting and risk distribution in ruling for captive insurance subsidiary situations.⁴⁹ The courts have generally found that

42. Gen. Couns. Mem. 39829.

43. 985 F.2d 1210 (3d Cir. 1993).

44. *Sound Health Ass'n v. Commissioner*, 71 T.C. 158 (1978), *acq.*, 1981-2 C.B. 2.

45. *Geisinger*, 985 F.2d at 1220.

46. *Geisinger Health Plan v. Commissioner*, 100 T.C. No. 26, No. 20793-90X, 1993 WL 137137 (T.C. May 3, 1993).

47. Treas. Reg. § 1.801-3(a) (as amended in 1974).

48. 312 U.S. 531 (1941).

49. See *Humana Inc. v. Commissioner*, 881 F.2d 247 (6th Cir. 1989) (holding that risk shifting and risk distribution occurred between insurance subsidiary and its brother-sister

an insurable risk of economic loss must be shifted from an insured to an insurer in order for a true insurance relationship to exist. Additionally, the courts have held that the risk may also have to be distributed among several unrelated insureds.

Utilization of the risk shifting and risk distribution concept by an HMO is unique since an HMO has obligated itself to assume a member's loss for obtaining health care services rather than actually providing indemnification to the subscriber. The IRS has been taking the position, on examination, that HMOs are not insurance companies if the HMO's assumption of the subscribers' risk of loss is offset by a retransfer of that risk to health care providers. This especially may occur under salary, capitation, or other fixed fee basis arrangements or where the HMO provides only incidental health insurance coverage.

In Revenue Ruling 68-27,⁵⁰ the IRS determined that a staff model HMO was not an insurance company. The IRS ruled that because physician care was the predominant activity of the HMO, the HMO was actually a health care provider and not an insurance company. The HMO's salaried physicians controlled the extent and cost of care, making the risk of loss more of a business risk rather than an insurance risk.

The significance of being taxed as an insurance company or regular Subchapter C corporation centers on the deductibility of the incurred but not reported (IBNR) claims loss accruals. The deductibility of IBNR loss is a complex issue. If taxed as an insurance company, an HMO is clearly entitled to a deduction for its IBNR losses.⁵¹ Additionally, as an insurance company, an HMO would be required to discount its reserves for tax purposes,⁵² discount its unearned premiums,⁵³ and reduce its losses incurred deduction by including fifteen percent of its dividends received deduction and fifteen percent of its tax-exempt investment income.⁵⁴

If an HMO is not taxed as an insurance company, then the IBNR reserve must meet the all-events test and the economic performance require-

affiliated companies). *AMERCO & Subsidiaries v. Commissioner*, 96 T.C. 18 (1991) (holding that risk shifting and risk distribution occurred where insurance subsidiary had unrelated insurance risk of between 52% and 74%), *aff'd*, 979 F.2d 162 (9th Cir. 1992); *Harper Group and Includible Subsidiaries v. Commissioner*, 96 T.C. 45 (1991) (holding that unaffiliated business of 29% was sufficient by itself to establish risk shifting and risk distribution), *aff'd*, 979 F.2d 1341 (1992); *Sears, Roebuck and Co. v. Commissioner*, 96 T.C. 61 (1991) (holding that insurance premiums were deductible by parent company where percentage of unrelated insurance business written by insurance subsidiary was 99.75%), *aff'd in part and rev'd in part*, 972 F.2d 858 (1992); *Ocean Drilling & Exploration Co. v. United States*, 24 Cl. Ct. 714 (1993) (holding that unrelated third party business of 44% to 66% is significant enough to result in both risk shifting and risk distribution necessary for insurance treatment), *aff'd*, 988 F.2d 1135 (Fed. Cir. 1993).

50. 1968-1 C.B. 315.

51. Rev. Rul. 70-643, 1970-2 C.B. 141.

52. I.R.C. §§ 832(b)(5)(A), 846 (Supp. 1993).

53. I.R.C. 832(b)(4).

54. I.R.C. §§ 832(b)(5)(B) and (C).

ments of Code section 461(h) to be deductible. Under the all-events test, all of the events must have occurred that will determine the fact of the liability, and the amount of the liability must be determinable with reasonable accuracy.⁵⁵ The all-events test generally may not be satisfied sooner than when economic performance occurs. If the fact of the liability occurs by providing services to the taxpayer by another person, economic performance occurs as the person performs the services.⁵⁶

Thus, it is unclear whether an HMO that is not taxed as an insurance company can accrue and deduct its IBNR losses. In *United States v. General Dynamics*,⁵⁷ the Supreme Court held that the last event necessary to fix the noninsurance company taxpayer's liability was not the receipt of medical care by members, but the filing of medical reimbursement claims. The Court stated that if the all-events test permitted the deduction of IBNR losses, there would have been no need for Congress to enact the insurance company provisions which explicitly allow for insurance companies to deduct the IBNR reserves.⁵⁸

Application of the *General Dynamics* decision to HMOs is difficult because the *General Dynamics* decision involved self-insurance by a noninsurance company. In making its decision, the Supreme Court recognized that the General Dynamics employees had certain motivations relating to job security to prevent or dissuade them from actually filing a claim even though the health care expenses were already incurred.⁵⁹ This is an important fact because such motivation is generally not present in health care plans such as HMOs, and, to the contrary, the physicians are actually motivated to file the claims to receive payment.

In several recent technical advice memoranda,⁶⁰ the IRS allowed the deduction for IBNR claims in the year the services were performed. The technical advice memoranda dealt with firms that offered mental health and substance abuse counseling services through their own clinics and entered into contracts with third-party vendors in order to provide special services beyond their staff's skills. Under the contracts, after the firms preauthorized the patient care to be provided by the outside specialist, the specialist was required to provide the service, and the firms were required to pay for it. The firm in each technical advice memorandum recorded a liability at the time of preauthorization.

The IRS held that preauthorization of the services does not achieve economic performance, because all events that determine the fact of the liability will not occur until the preauthorized services are performed.⁶¹ However, the IRS did allow the deduction for the accrual for services that

55. Treas. Reg. § 1.461-1(a)(2) (as amended in 1992).

56. I.R.C. § 461(h)(2)(A)(i) (Supp. 1993).

57. 481 U.S. 239, 239-40 (1987).

58. *Id.* at 246-47.

59. *Id.* at 244-45.

60. Tech. Adv. Memos. 92-030-02 (Apr. 11, 1991) & 92-030-03 (Apr. 11, 1991).

61. Tech. Adv. Memos. 92-030-02 (Apr. 11, 1991) & 92-030-03 (Apr. 11, 1991).

had been performed. The firm was required to accrue the expense in the year the services were actually performed.

Code section 461(h)(3)(A) provides for the recurring item exception to the economic performance rules. Under this exception, a deduction may be permitted if:

1. The all-events test, without regard to economic performance, is satisfied during such taxable year,
2. Economic performance occurs within the shorter of eight and a half months or a reasonable time after the close of such tax year,
3. The item is recurring in nature and the taxpayer consistently treats similar items as incurred in the taxable year in which the all-events test is met, and
4. The item is not material or the accrual of the item in the year that the all-events test is met results in a better matching of income and expense.⁶²

While the second and third requirements are generally easily met by HMOs, the first and fourth requirements are not so easily met. IBNR losses are generally a significant item so an HMO must prove that the accrual of such a large liability in the taxable year results in the more proper matching of income and expense.

D. Tax Policy Decisions for HMOs

Larger HMOs likely will be players in the reformed health care environment. Accordingly, it is critical that Congress decide what their tax status should be. Should they be tax-exempt? Should they be taxed as noninsurance C corporations? Or, should they be taxed as insurance companies? These questions should be answered as a part of a comprehensive approach to health care reform. Congress cannot expect these organizations to efficiently provide universal health care coverage if they are confronted daily by an unpredictable status for federal income tax purposes.

The authors believe that tax exemption for large HMOs, which are generally IPA models, is inappropriate. First, they most likely will not qualify for tax-exempt status under traditional Internal Revenue Code standards. And second, tax exemption for these organizations without tax exemption for other types of organizations involved in health care provision would be inappropriate.

Taxing HMOs as noninsurance C corporations is inappropriate as well. Taxing HMOs similar to industrial enterprises like General Dynamics fails to recognize the significant distinctions that exist between these types of entities. IPA model HMOs are in the business of accepting subscriber premiums in return for some level of guarantee that the subscriber will receive the health care services for which the subscriber contracted. In

62. I.R.C. § 461(h)(3)(A).

contrast, General Dynamics and similar industrial companies are in the business of producing goods. As a part of managing their businesses, these companies may choose to "self-insure" their employees' health care expenses. This decision is integrally related to the industrial company's business of employing people to produce goods and recognizing that the employees will require some form of health care benefits. In other words, the issue of "self-insuring" employees' health care benefits is simply one issue among many that must be addressed in managing industrial enterprises. In the HMO setting, providing a guarantee of health care coverage *is* the business. It is not part of the business or directly related to another business. It is the primary purpose for which HMOs are formed and operated.

Accordingly, the authors believe HMOs should generally be taxed as insurance companies. They are in the business of providing a guarantee that their subscribers will receive health care services. If they can contract for these services from physician networks, hospitals or other providers at a reasonable cost, they will succeed. If not, they will not be able to meet their guarantee to their subscribers and will fail, just as commercial insurance companies that are not able to fulfill their guarantees. The fact that HMOs enter favorable contracts with physician networks and hospitals does not detract from the nature of the relationship between the HMO and its subscribers.

In the context of health care reform, HMOs that are able and willing to participate in providing coverage to individuals and small business employees should be provided tax incentives similar to those recommended for Blue Cross-Blue Shield organizations. In summary, HMOs and all organizations that provide health care coverage in the revolutionized health care environment should be taxed in a consistent manner.

IV. MEDICAL MALPRACTICE INDUSTRY

A. Background

In addition to Blue Cross-Blue Shield Organizations and HMOs, the medical malpractice insurance industry will likely play a major role in any health care reform. Over the past two decades the composition of the medical malpractice industry has changed significantly. Prior to the 1970s, the major commercial insurance carriers dominated the medical malpractice insurance industry. However during the mid-1970s the composition of the medical malpractice industry changed dramatically with the withdrawal from many of the geographic markets of the major commercial malpractice insurance carriers.⁶³ The major carriers exited the market due to the low rate of return being generated with the medical malpractice product as the result of increased litigation and large settlements awarded by the courts.

63. John K. Meager, *Commentator Criticizes Rules for Malpractice Insurers*, 6 *INS. TAX. REV.* 1303, 1304 (1992).

Physicians along with their state medical association were forced to form mutual insurance companies under their states laws to insure against the malpractice risks that the physicians were facing.⁶⁴ Today, these insurance companies formed during the late 1970s and early 1980s, along with a few major commercial insurance carriers, are the predominant players in the medical malpractice market.⁶⁵

The medical malpractice industry has faced lagging premium growth during the past several years; however, the industry's underwriting results have continued to improve as a result of significant premium increases during the mid-1980s, declining claims frequency and an increased focus on preventative medicine.⁶⁶ While growth in medical malpractice premiums has lagged over the past several years, the cost of providing medical malpractice insurance has increased more rapidly than any other cost associated with physician practice, rising at an annual rate of 21.4 percent.⁶⁷

B. *The Tax Reform Act of 1986*

A significant component of the costs associated with providing malpractice insurance coverage is the federal income tax burden imposed on the industry. Although medical malpractice insurers are taxed under the same laws as other property and casualty insurance companies, the 1986 Act had a more significant impact on the medical malpractice industry than it did on the property-casualty industry as a whole.⁶⁸ The 1986 Act introduced several significant provisions that affected the property and casualty insurance industry, including the requirements that unpaid losses and loss adjustment expenses be discounted, that twenty percent of the change in unearned premium reserves be included in income, and that the losses incurred deduction be reduced by fifteen percent of the dividends received deduction and fifteen percent of tax-exempt investment interest.

1. Reserve Discounting

For tax years beginning before 1987, the change from the beginning of year balance to the end of year balance in the reserve (liability) for unpaid losses shown on the annual statement⁶⁹ served to increase or decrease the

64. *Id.* at 1304.

65. *Id.*

66. Diane Ferraiolo, *General Liability Medical Malpractice Security and Fidelity 1991*, A.M. BEST REV., Dec. 1992, at 23.

67. WHITE HOUSE, FACT SHEET ON HEALTH CARE LIABILITY REFORM (May 15, 1991).

68. The disparity in tax treatment between these industries results primarily from the loss reserve discounting provisions of I.R.C. § 846 and the unearned premium discounting provisions of Code section 832(b)(4)(B). See discussion *infra* Parts IV.B(1) & (2).

69. Code section 811(a) provides that, to the extent not inconsistent with the accrual or other permitted method of accounting, all computations entering into the determination of taxes imposed shall be made in a manner consistent with the manner required for the purposes of the annual statement (financial statements) approved by the National Association of

deduction for incurred losses. From a federal income tax perspective, the only potential limiting factor was that reserves for unpaid losses represent a fair and reasonable estimate of the amount the company will be required to pay. If the IRS determines that estimates of unpaid loss reserves are in excess of the actual liability, such excess will be disallowed as a deduction.⁷⁰ For years beginning after 1986, the 1986 Act significantly changed the tax treatment of unpaid loss reserves. Based on the premise that property and casualty insurers should not be allowed a full deduction on their current tax return for losses that will be paid sometime in the future, the Act provided for discounting of unpaid loss reserves.⁷¹ Discounting is intended to account for the time value of money, which was previously not accounted for under prior law. Thus, for years beginning after 1986, losses incurred will be adjusted for the change in *discounted* unpaid loss reserves.⁷² For example:

Assume that Medical Malpractice Company of America (MMCA) has unpaid losses and loss adjustment expenses (unpaid loss reserves) shown on its NAIC approved annual statement of \$100,000 at the beginning of the year and \$150,000 at the end of year. Under pre-1986 Act provisions, the increase in the unpaid loss reserves of \$50,000 would be deductible in computing taxable income. However, under the 1986 Act, the unpaid loss reserves must first be discounted for the time value of money to determine the applicable increase or decrease in computing taxable income. Thus, under the 1986 Act, the \$50,000 increase in the annual statement reserves would result in a deduction for tax purposes of only \$40,000, computed as follows:

	—Annual Statement—	—Tax Return—
	Undiscounted Unpaid Loss Reserves	Discounted Unpaid Loss Reserves
End of Year Balance	\$150,000	\$125,000
Beginning of Year Balance	<u>(100,000)</u>	<u>(85,000)</u>
Change/Deduction	\$50,000	\$40,000

Thus, discounting cost MMCA \$10,000 (\$50,000-\$40,000) in deductions.⁷³

Insurance Commissioners (NAIC). The NAIC approved annual statement is basically a detailed set of financial statements that are governed by statutory accounting principles established by the NAIC. Annual statements are generally required to be filed with the applicable state departments of insurance, on a calendar year basis, in each state in which the insurance company does business.

70. Treas. Reg. § 1.832-4(b) (as amended in 1992).

71. I.R.C. § 846.

72. *Id.*

73. This difference between annual statement income and taxable income would be shown as a \$10,000 book-tax, or "M-1", adjustment on MMCA's calendar year Form 1120-PC, U.S. Property and Casualty Insurance Company Income Tax Return.

The following three items are necessary to compute discounted unpaid loss reserves:

1. Undiscounted unpaid losses and loss adjustment expenses,
2. Applicable interest rate, and
3. Applicable loss payment pattern.⁷⁴

Final regulations under Code section 846, issued September 1992, require that a company compute its loss discount factors based on its own historical loss payment patterns (with respect to eligible lines) or industry loss payment patterns.⁷⁵ To use historical payment patterns companies must have sufficient experience, which is defined as having loss payment information available for all accident years shown on Schedule P of the Company's National Association of Insurance Commissioner's (NAIC) Annual Statement two years before the applicable determination year.⁷⁶

Unlike other lines of insurance, medical malpractice insurance policies are basically provided through two different coverage forms: occurrence policies and claims-made policies. Occurrence policies provide coverage for all claims that arise from a given accident year, regardless of when the claim is reported. Claims-made policies, on the other hand, provide coverage only for claims reported during the policy year. The majority of medical malpractice insurers utilize the claims-made policy because the London reinsurance market indicated in the mid 1980s that it would not provide reinsurance⁷⁷ coverage to occurrence writers.⁷⁸ The discounting provisions of Code section 846 have proven especially complex and costly for the medical malpractice industry primarily due to the shift from occurrence type policies to claims-made type policies and the industry's generally long-tail payout pattern.

The election for medical malpractice insurance companies to use their own experience to develop discount factors requires that the company have at least ten years of data available (number of accident years shown on Schedule P⁷⁹ of the NAIC Annual Statement for medical malpractice lines of business). Because of this requirement, many malpractice companies organized by physician groups and state medical associations in the insurance crisis of the mid-1970s were initially unable to utilize their own payment patterns. Additionally, many of these medical malpractice companies had issued claims-made policies since their inception or had switched from occurrence policies to claims-made policies during the 1980s; thus, these

74. I.R.C. § 832(b)(5).

75. Treas. Reg. § 1,846-0 to -6 (1992).

76. I.R.C. § 846(c).

77. Reinsurance is generally a transaction whereby one insurance company transfers risk, either underwriting or investment, arising out of an insurance policy or group of policies, to another insurance carrier.

78. See Meager, *supra* note 58, at 1303.

79. Schedule P of the NAIC annual statement provides detailed information on unpaid losses and loss adjustment expenses for each line of insurance business.

insurance companies were required to use the IRS developed industry payment patterns that were compiled primarily from occurrence type policy data.

The medical malpractice line of business has a long payment pattern relative to the other property and casualty lines of insurance business. It is not uncommon for medical malpractice companies to have claims paid out ten to fifteen years after the related premiums are collected. Additionally, payment patterns for claims-made policies are approximately two years faster than occurrence policies; thus the IRS-published discount factors are generally much lower than claims-made developed policy factors.⁸⁰ This difference between claims-made and occurrence type policies creates an excessive tax burden on claims-made policy writers, which are forced to utilize the industry published factors in discounting loss reserves.

In March of 1991, the IRS published Revenue Procedure 91-21⁸¹ which was intended to provide relief to medical malpractice insurers. This revenue procedure allowed malpractice companies with claims-made policies to elect to utilize the IRS published Composite Schedule P discount factors in place of the industry factors. The payment pattern utilized in calculating Composite Schedule P factors are generally closer to claims-made payment patterns for medical malpractice insurance lines. Revenue Procedure 91-21 applied retroactively to 1987; however, it expired after the 1991 accident year. Thus, Composite Schedule P discount factors are no longer available for post-1991 accident years for malpractice insurers.

In response to expiration of Revenue Procedure 91-21, the IRS issued Revenue Procedure 92-76⁸² in September of 1992. Revenue Procedure 92-76 provides relief to malpractice insurers by reducing the number of years required to utilize their own historical experience from ten years to five years, as long as a total of seventy-seven percent of estimated losses were paid in any two of the five years. This benefited only a few medical malpractice companies that have been in business between five and ten years as of 1992.

Today, no discount factors exist that are applicable to the claims-made line of insurance business for medical malpractice insurance even though there is a separate schedule in the NAIC annual statement that requires certain claims-made information be provided. The Physicians' Insurers Association of America has requested the IRS to provide a separate line of factors to reflect the true payment patterns⁸³ for claims-made policies of medical malpractice insurance companies. Treasury's issuance of Revenue Procedure 92-76 only indirectly addressed the problem encountered by medical malpractice insurers and had a limited impact on the industry as a whole. Without a legislative initiative, malpractice insurers will be forced

80. See Meager, *supra* note 58, at 1303.

81. 1991-1 C.B. 525.

82. 1992-38 I.R.B. 28.

83. See Meager, *supra* note 58, at 1303.

to continue to increase malpractice premiums to pay for increased taxes and compliance costs generated by complicated and inequitable unpaid loss discounting provisions. Increased malpractice premiums directly impact the cost of health care in the United States and this could be avoided, in this case, through appropriate legislative action.

2. Unearned Premiums

Under the 1986 Act, property and casualty insurance companies are required to reduce their unearned premiums by twenty percent. Therefore, only eighty percent of the annual increase in unearned premiums is deductible and, conversely, only eighty percent of the annual decrease in unearned premiums is includible in taxable income.⁸⁴ Under transitional rules, property and casualty insurance companies were also required to include in taxable income twenty percent of their unearned premium balances as of the end of the last taxable year beginning before 1987. This inclusion was spread over a six year period, with 3.33 percent of the unearned premium amount being included in taxable income in each year after 1986 and before 1993.⁸⁵ This twenty percent discount to unearned premiums is considered by many to be unfair to the medical malpractice industry. Congress' rationale for enacting this provision was effectively to disallow the immediate deduction for commissions incurred in selling property and casualty insurance.⁸⁶ The physician and state medical association malpractice companies generally do not incur the large up-front commission expenses which many other property and casualty insurance companies in other lines of business incur. Thus, Congress' proxy approach is unfair to companies, such as medical malpractice companies, which have no meaningful commission expenses. This inequity should be and can be resolved legislatively in order to put the local medical malpractice companies that generally do not incur and deduct up-front commissions on equal footing with their national competitors. Such legislation would significantly reduce the tax burden imposed on the medical malpractice industry and, in turn, should help to lower the cost of obtaining malpractice insurance.

3. Proration

The 1986 Act also imposed a proration requirement on property and casualty insurance companies' tax-exempt earnings by reducing the deduction for losses incurred by fifteen percent of certain tax-exempt interest and dividends received deductions attributable to stock or obligations acquired after August 7, 1986.⁸⁷ This proration provision was enacted under the charge that property and casualty insurance companies were avoiding federal

84. I.R.C. § 832(b)(4)(B).

85. I.R.C. § 832(b)(4)(C).

86. '86 ACT BLUE BOOK, *supra* note 1, at 595.

87. I.R.C. § 832(b)(5)(B).

income taxation by investing premiums received in tax-exempt investments and taking the tax deduction in the form of claims when they were paid with earnings from the tax-exempt investments.⁸⁸ The proration provision applies to all property and casualty insurance companies, including medical malpractice companies.

The impact of proration is significant to most every property and casualty insurance company and is considered unfair by many in the industry. Limiting the amount of tax-exempt income that property and casualty companies can exclude from taxable income is inequitable because no similar tax provisions are in place for noninsurance companies. The resulting tax burden imposed by the proration provisions dramatically increases the cost of providing both accident and health, and medical and malpractice, insurance. These costs are indirectly passed on to the insureds through higher premium levels. Legislative action to eliminate or reduce the proration provisions would greatly reduce the costs associated with providing health care.

C. Captives

Because of the significant costs of obtaining malpractice insurance, many large health care providers such as hospital groups have been examining alternatives to purchasing malpractice and other liability lines of insurance business from the commercial market. One alternative to purchasing commercial insurance is for companies to self-insure or form a captive insurance subsidiary.⁸⁹ Many companies believe that they can better manage the costs associated with malpractice insurance by forming a captive. These companies believe that they can lower litigation costs and provide better preventative education than the malpractice insurance companies because the captive has a direct interest in the results.

Recent court decisions have provided judicial support for companies to establish insurance subsidiaries to insure for their risks and to obtain a current tax deduction for the premiums paid to their insurance subsidiary. These decisions generally provide that an affiliated insurance subsidiary may qualify as a true insurance company if certain requirements such as risk shifting, risk distribution and other insurance characteristics exist.⁹⁰ To

88. '86 ACT BLUE BOOK, *supra* note 1, at 598.

89. A captive insurance company is generally an organized insurance company formed for the purpose of serving one or a limited number of policyholders. These companies operate similar to commercial insurance carriers, except that the risks are shared by a limited number of policyholders. These companies primarily provide insurance coverage to related parties, such as a parent company, brother-sister affiliated companies, trade associates, trade groups, etc.

90. *See* Humana Inc. v. Commissioner, 881 F.2d 247 (6th Cir. 1989) (holding that risk shifting and risk distribution occurred between insurance subsidiary and its brother-sister affiliated companies); AMERCO & Subsidiaries v. Commissioner, 96 T.C. 18 (1991) (holding that risk shifting and risk distribution occurred where insurance subsidiary had unrelated insurance risk of between 52% and 74%), *aff'd*, 979 F.2d 162 (9th Cir. 1992); Harper Group and Includible Subsidiaries v. Commissioner, 96 T.C. 45 (1991) (holding that unaffiliated

obtain risk shifting and risk distribution, the cases suggest that unrelated third party insurance risks may also need to be insured or a substantial number of brother-sister related companies must obtain insurance from the insurance subsidiary. As a true insurance company, an insurance subsidiary can defer income recognition on unearned premiums and also deduct reserves for unpaid losses, including reserves for incurred but not reported losses. Additionally, the premium payments made by the parent or brother-sister company to the insurance subsidiary may be deductible by the parent or affiliate as an ordinary and necessary business expense.⁹¹

Hospital groups and other health care providers are pursuing the captive insurance alternative as a means to reduce the cost of health care. However, many providers are hesitant to commit to this alternative because of the uncertainty that continues to exist in the tax law with respect to captive insurance arrangements, even in light of recent taxpayer court victories. The IRS continues to challenge arrangements parallel to those already decided in recent cases. In order to resolve this problem so providers can operate their businesses as efficiently as possible, congressional action may be necessary.

In order to alleviate the inequities that arise when the general property and casualty insurance taxation scheme is applied to medical malpractice insurers, Congress should first instruct the IRS to provide for loss reserve discount factors that parallel actual medical malpractice industry experience. Second, Congress should grant medical malpractice companies an exception from the twenty percent "haircut" of Code section 832 because the companies have little commission expenses rather than commission expenses which average twenty percent of their unearned premiums reserve. Third, Congress should consider repealing the fifteen percent reduction in the losses incurred deduction for all property-casualty insurers rather than continuing to single out insurance companies for such treatment. Finally, Congress should instruct the IRS to clarify the status of captive medical and hospital malpractice companies in order to ease the continuing burden of trying to comply with shifting rules.

V. CONCLUSION

While this essay provides several specific suggestions for the improvement of insurance tax policy with respect to the reform of the health care system, the key for Congress will be to recognize the role that Blue Cross-

business of 29% was sufficient by itself to establish risk shifting and risk distribution), *aff'd*, 979 F.2d 1341 (1992); *Sears, Roebuck and Co. v. Commissioner*, 96 T.C. 61 (1991) (holding that insurance premiums were deductible by parent company where percentage of unrelated insurance business written by insurance subsidiary was 99.75%), *aff'd in part and rev'd in part*, 972 F.2d 858 (1992); *Ocean Drilling & Exploration Co. v. United States*, 24 Cl. Ct. 714 (1993) (holding that unrelated third party business of 44% to 66% is significant enough to result in both risk shifting and risk distribution necessary for insurance treatment), *aff'd*, 988 F.2d 1135 (Fed. Cir. 1993).

91. I.R.C. § 162 (Supp. 1993).

Blue Shield plans, HMOs and medical malpractice insurers play in the provision of health care in the United States. Congress should strive to provide consistent rules which enhance the efficiency of private insurers to provide health insurance in the evolving health care system as the revenue focused system of today shifts toward a cost focused—managed care—system reminiscent of the first Blue Cross plans of the 1930s. Congress should carefully consider the integral role of insurance tax policy, as fiscal pressures and demographic realities drive us inexorably back to the future.